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450.124: Behavioral Health Services

(A) Behavioral Health Contractor. Except as provided in 130 CMR 450.124(B) and (C), all behavioral health services covered by the MassHealth agency's contract with the behavioral health contractor (the Contractor) are authorized, provided, and paid solely by the Contractor. Payment for such services is subject to the terms of the Contractor's provider contracts including, but not limited to, provisions governing service authorization and billing requirements. Any provider seeking a contract with the Contractor should contact the Contractor directly.

(B) Emergency Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the Contractor. Providers should refer to MassHealth bulletins for information and guidance on submission of claims for emergency department behavioral health visits.

(C) Services to Exempt Members. Services provided to the following MassHealth members are not subject to 130 CMR 450.124:

- (1) members who are enrolled in an MCO, Accountable Care Partnership Plan, SCO, or ICO; and
- (2) members who are excluded from participating in managed care under 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care* unless such member is enrolled with the behavioral health contractor pursuant to 130 CMR 508.001(E).

(130 CMR 450.125 through 450.129 Reserved)

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450.130: Copayments Required by the MassHealth Agency

(A) Copayment Requirement. The MassHealth agency requires its members to make the copayments described in 130 CMR 450.130(B), up to the ~~calendar-year~~ maximum described in 130 CMR 450.130(C), except as excluded in 130 CMR 450.130(D) and (E). Providers may collect copayments only in the amounts and for the services listed in 130 CMR 450.130(B). If the payment rate for the service is less than the copayment amount, the member must pay the payment rate for the service ~~minus one cent~~. Members who are enrolled in MCOs, Accountable Care Partnership Plans, SCOs, and ICOs must make copayments in accordance with the such entity's copayment policy. Those copayment policies must

- (1) be approved by the MassHealth agency;
- (2) exclude the persons and services listed in 130 CMR 450.130(D) and (E);
- (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 450.130(B); and
- (4) not exceed the ~~calendar-year or quarterly~~ maximums set forth in 130 CMR 450.130(C). (See also 130 CMR 506.011 through 506.0189, 508.004(C), 508.005(C), 508.006(A)(3), 508.007(G), 508.008(G), and 520.036 through 520.040.)

(B) Services Subject to Copayments. MassHealth members are responsible for making the following copayments for pharmacy services, unless excluded in 130 CMR 450.130(D) or (E).

- (1) \$1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and
- (2) \$3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by MassHealth.

(C) Maximum Cost Sharing. ~~Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B), up to the maximum of \$250 for pharmacy services per calendar year.~~

- (1) ~~Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B), up to a monthly maximum of 2% of applicable monthly income. Each member's monthly copayment cap will be calculated using 2% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, and assigning the member a monthly cap of the nearest \$10 increment that corresponds to 2% of the applicable income without exceeding 2%. A more detailed explanation of this calculation is publicly available on MassHealth's website.~~
- (2) ~~Members are responsible for the MassHealth premiums described in 130 CMR 506.012 up to a monthly maximum of 3% of applicable monthly income, except no such limit applies to CommonHealth members. Each member's monthly premium cap will be calculated using 3% of the lowest income in the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable. A more detailed explanation of this calculation is publicly available on MassHealth's website.~~

(D) Excluded Individuals.

- (1) The following individuals do not have to pay the copayments described in 130 CMR 450.130(B):
 - (a) members younger than 21 years old;

(b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15th, she is exempt from the copayment requirement until August 1st);

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- (c) MassHealth Limited members;
- (d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;
- (e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for individuals with intellectual disabilities or who are admitted to a hospital from such a facility or hospital;
- (f) members receiving hospice services;
- (g) persons receiving medical services through the EAEDC Program pursuant to 130 CMR 450.106, if they do not receive MassHealth CarePlus, MassHealth Standard, or MassHealth Family Assistance;
- (h) members who are former foster care individuals and who are eligible for MassHealth Standard until they reach the age of 21 or the age of 26, as specified in 130 CMR 505.002(H): *Eligibility Requirements for Former Foster-Care Individuals*;
- (i) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law;
- (j) “referred eligible” members, who are:
 - 1. persons who receive Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA) and who receive MassHealth Standard under 130 CMR 505.002(A)(2) or 130 CMR 519.002(B);
 - 2. persons who receive Transitional Aid to Families with Dependent Children (TAFDC) cash assistance from the Department of Transitional Assistance (DTA) and who receive MassHealth Standard under 130 CMR 505.002(A)(3);
 - 3. children, young adults, and parents and caretaker relatives who receive Emergency Aid to the Elderly, Disabled and Children (EAEDC) cash assistance and who receive MassHealth Standard under 130 CMR 505.002(K) or 130 CMR 519.002(D), MassHealth Family Assistance under 130 CMR 505.005(G) or 130 CMR 519.013(C), or MassHealth CarePlus under 130 CMR 505.008(B);
 - 4. children receiving medical assistance under 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*, because they are receiving Title IV-E or state-subsidized adoption or foster-care assistance;
 - 5. persons who receive extended eligibility for MassHealth Standard under 130 CMR 505.002(L) or 130 CMR 519.002(C); and
 - 6. persons who receive MassHealth Standard or CarePlus because they are eligible for Refugee Medical Assistance (RMA) under 130 CMR 522.002: *Refugee Resettlement Program*; and
- (k) members whose applicable income for the purposes of calculating copayments is at or below 50% of the FPL **when adjusted for family size**.

~~(2) Members who have accumulated copayment charges totaling the calendar year monthly maximum of for \$250 on pharmacy services do not have to pay further MassHealth copayments on for pharmacy services during the calendar year month in which the member reached the MassHealth copayment maximum for pharmacy services.~~(23)

Members who are inpatients in a hospital do not have to pay a copayment for pharmacy services provided as part of the hospital stay.

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(E) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 450.130(B):

- (1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
- (2) detoxification and maintenance treatment of an individual for substance use disorders using FDA approved medications (including methadone, buprenorphine, buprenorphine/naloxone, and naltrexone);
- (3) preventive services assigned a grade of ‘A’ or ‘B’ by the United States Preventive Services Task Force (USPSTF), or such broader exclusion as specified by MassHealth;
- (4) all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP);
- (5) smoking cessation products and drugs;
- (6) emergency services; and
- (7) provider-preventable services as defined in 42 CFR 447.26(b).

(F) Notice to Members about Exclusions from the Copayment Requirement. Pharmacies must post a notice about MassHealth copayments in areas where copayments are collected. The notice must be visible to the public and easily readable and must specify the exclusions from the copayment requirement listed in 130 CMR 450.130(D) and (E), and instruct members to inform providers if members believe they are excluded from the copayment requirement.

(G) Collecting Copayments.

- (1) A member must pay the copayment described in 130 CMR 450.130(B) at the time the service is provided unless the member is exempt under 130 CMR 450.130(D) or (E), claims that he or she is exempt from the copayment, or claims that he or she is unable to make the copayment at the time the service is provided. The member's inability to make the copayment at the time service is provided does not eliminate the member's liability for the copayment, and providers may bill the member for the copayment amount.
- (2) The MassHealth agency will deduct the amount of the copayment from the amount paid to the provider, whether or not the provider collects the copayment from the member, unless the member or service is exempt according to 130 CMR 450.130(D) or (E). Providers must not deduct the copayment amount from the amount claimed.
- (3) Providers may not refuse services to any members who are unable to pay the copayment at the time service is provided.

(H) Receipt. The provider must give the member a receipt identifying the provider, service, date of service, member, and amount paid.

(I) Recordkeeping. Providers must keep all records necessary to determine if a copayment was collected from a member for a service on a specific date.

(130 CMR 450.131 through 450.139 Reserved)